Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7503	A. BUILDING: _____ B. WING _____	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments The annual Licensure survey and complaint investigation #30721, #31240, and #31510, were completed at Mayfield Rehabilitation Center on May 22, 2013. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001		

Division of Health Care Facilities

Debbie Bowers
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 6/13/13

JUN 14 2013